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INJECTION TREATMENT OF INTERNAL HAEMORRHOIDS.

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The Injection treatment of haemorrhoids was originated in America by a Dr. Mitchell of Illinois in the late nineties. He however kept his formula and technique a secret and sold it to whoever cared to purchase it. Naturally it fell into the hands of quacks and 'pile curers' who did very extensive business, so that the treatment fell into disrepute and was not practised by the regular profession. Slowly however the method has been gaining ground and at present it holds the high place it deserves in the treatment of this common surgical condition, and can be used with perfect satisfaction and safety in almost every case of uncomplicated internal haemorrhoids.

The great advantage of this is that the patient is not confined to bed and loses but a few hours from his work or business. The treatment is painless. The relief is immediate and there is steadily progressive improvement. There is little or no risk in the injections themselves provided that the treatment is carried out properly. Especially in India, when piles cases come for treatment at an advanced stage of anaemia and prolapse, when operative methods are absolutely contraindicated injections are the only possible course of treatment and give very good results.

The technique is comparatively simple and experience develops confidence and skill in its application, although the beginner will do well to observe the procedure in the hands of a competent operator before attempting it.

The Technique of Injection.—There are two methods of injecting piles. One is by what is known as the strong solution and the other by means of a weak solution in oil. The latter is now the recommended procedure and is suggested as the better solution.

The Solutions.—The weak solution consists of 5 per cent carbolic in almond oil. (It is recommended that the solution be prepared as follows: Pure carbolic is melted by warning the bottle and twelve ounces of the acid are poured into a large measure and twelve ounces of warm almond oil are then added and the two substances are then thoroughly shaken. This makes up a 50 per cent solution and from it a 5 per cent solution can be made by diluting one oz. of the stock solution with 9 ounces of almond oil). The strong solution consists of

Liquefied carbolic acid	48 m.
Glycerine	ʒ ii.
Distilled water	ʒ ii.

This makes a 20 per cent solution. These two solutions are all that are necessary to treat any case by injections.

The Syringe.—In the case of the oily solution in the absence of a special syringe, the ordinary 10 or 20 c. c. syringe used in local anaesthesia, having a long needle and fitting on to the syringe with a bayonet catch can be used. For the stronger solution the long narrow metal syringe as used by dentists is preferable. Both syringes should be fitted with ring handles so that they can be easily held in the right hand.

The Speculum.—For the proper performance of this injection treatment, it is necessary that the right type of speculum be used. Lockhart's fenestrated speculum, although quite satisfactory for the examination of the rectum is not useful here, as the piles prolapse into the window and prevent proper approach to the area above the piles region which is necessary when the oily solution is injected. Therefore, the speculum recommended is the short tubular tpye which consists of a hollow tube with an obtutator fitting into it. After the speculum has been passed and the obtutator removed, an excellent view of the rectum is obtained.

Illumination.—An electric head light is the best, but in its absence an ordinary torch could easily illuminate the interior of the rectum.

The Injection.—The proctoscope is introduced into the rectum after having been lubricated with vaseline or olive oil, and the piles made out.

The proctoscope is still further pushed in until the area above the piles region is reached. The syringe is filled with 2 to 4 c.c. of the solution in oil and the needle passed through the speculum pierces the mucous membrane. After withdrawing the piston slightly, to avoid the point being in a vein, the injection is made steadily. Enough fluid is injected to produce a swelling of the mucous membrane which usually turns pale and over which small blood vessels can be seen coursing producing the so called 'striation sign.' When this appears enough solution has been injected. The beginner in injection therapy may not appreciate the striation sign and he should be satisfied if about 3 c.c. are injected into one area. On withdrawing the needle there should be no bleeding or only a tiny trickle of blood from the puncture spot which can be stopped by pressure by a piece of gauze passed through the proctoscope. A similar injection is again made in another area of the rectum and the proctoscope removed. A record should be made of the site of injection and the amount of solution used and the patient told to report himself in a week's time. A tablespoonful of Liq. Paraffin should be taken every night until treatment is completed. The only precaution necessary in the after treatment is that the patient should not stand about more than is necessary and should not take violent exercise for a couple of days.

With the stronger solution the technique is somewhat different. The needle is plunged into the substance of the purplish pile mass itself. As the solution is being injected the pile visibly changes in appearance and becomes greyish in patches and gets larger in size. Not more than 5 to 7 m. of the strong solution is injected into each pile and not more than two piles should be tackled at a time.

The patient is injected again in a similar way a week later with both types of solutions and three or four such treatments ought to be enough for any ordinary case.

The rationale of the treatment is as follows; briefly it might be said that a mild aseptic inflammatory process takes place. Dilatation of the vessels, emigration of leucocytes and a trausudation of lymph to the perivascular tissues occurs. Later the exudate becomes plastic, adhesions form and new blood vessels enter the newly formed connective tissue. Organization is followed by contraction and obliteration of the dilated veins and finally the mucosa becomes firmly adherent to the muscle wall making the cure complete. Needless to say, in addition to the effects of fibrosis, there will be coincident thrombosis of the veins caused by the entrance of the needle into

the haemorrhoidal mass as well as due to the effect of the phenol on the endothelial lining of the vessels.

Complications and Contraindications.—The only complication which is at all likely to arise is when the stronger solution is used. The solution may be injected too near the skin, when some of it seeps back beneath the skin causing a tender and painful mass. This complication readily yields to hot hip baths given twice a day for two or three days. Contraindications to this method of treatment are piles complicated by fissure or fistula, and strangled or inflamed piles. Even in advanced cardiac or hepatic conditions, piles can be injected if necessary making the patient's life comfortable.

In this article two types of solutions have been recommended. It must be said however that the weaker solution in oil is the one preferred nowadays as giving better and more rapid results and the least amount of discomfort to the patient. But the stronger solution is useful in cases where a single pile is bleeding profusely for prompt arrest, in cases where only the smaller sized window type of speculum can be used (in some cases the tubular type of speculum causes great pain on introduction) and finally in inexperienced hands, the technique with the stronger solution will be found easier. A combination of both methods should give the best results.

Summing up, it might be said that if the advantages and indications of this method of treatment be more widely recognised and the technique carefully followed, operative methods of treatment with all their attendant discomforts and complications should become almost obsolete in the therapy of Internal Haemorrhoids.

30 MAY 1937
MADRAS

CASE REPORT.

DR. J. A. S. MASILAMANI, M.B.B S.,

Honorary Assistant Physician, Govt. General Hospital, Madras.

Male, Hindu. Age, 26. Occupation, Police Constable.

Complaint.—Headache, vomiting and impaired vision since 20 days. Started 6 months before admission with indigestion, vomiting and headache, lasting for 3 days at a stretch and recurring at intervals of 3 days for a period of 3 months. Four months later he had convulsions, headache and vomiting. Progressive failure of vision during the last 45 days.

On admission.—No signs of left ventricular hypertrophy, blood vessels slightly thickened. Pulsation of the aorta visible in the umbilical region.

Ophthalmoscopic examination.—Flame shaped haemorrhages—Disc pale—edges blurred.

Mental Condition.—Apathetic, not able to answer questions.

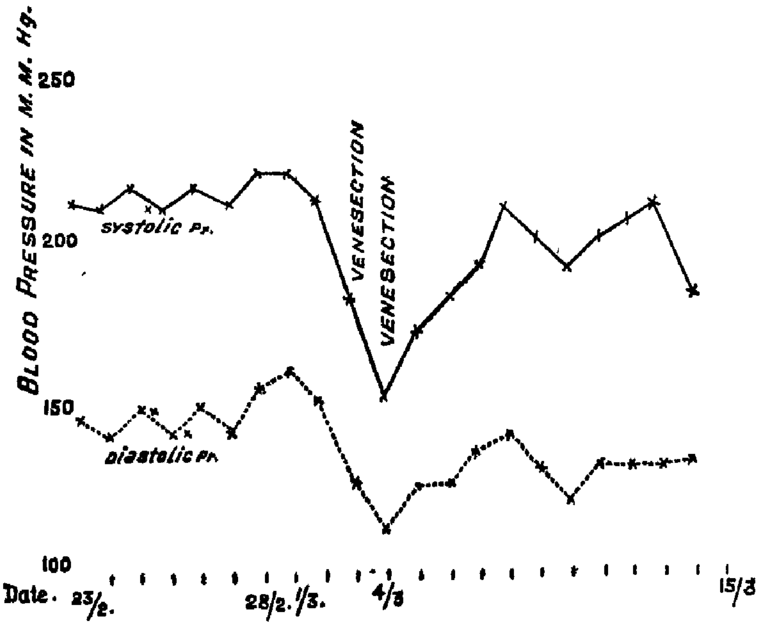
Urine —25-2-1937. Alkaline. Sp Gr. 1011, Albumen 0·25% Deposit—Phosphates, Epithelial cells, Hyaline casts and R. B. C.

27-2-1937. Alkaline, Albumen 0·15%.

		Normal.
Urea clearance test.		
Urine volume in 1 hour	56 c.c.	
Urine urea	0·599%	1—2%
Blood urea.	110 mg.	20—40 mg.
% average normal.	9·7%	60%
Blood cholesterol.	160 mg.	140—160 mg.
Non-Protein Nitrogen.	128·6 mg.	20—40 mg.
Cerebro-spinal fluid.—		
Total proteins.	70 mg. %	20—30 mg. %
Globulin.	Trace.	Absent.
Chlorides.	690 mg. %	700 mg. %
Urea.	103 mg. %	20—40 mg. %

Treatment.—Put on mixture containing Diuretin and magsulphas throughout his stay in hospital, 25 c.c. of 25 per cent Glucose given intravenously almost daily. The patient felt comfortable with the Glucose injections and was daily asking for it. Bromides and aspirin failed to give any relief to his headache so much so we had to resort to the Glucose injections sometimes twice a day which invariably gave relief for at least a few hours. Lumbar puncture was done twice and 30 per cent saline intravenously once. Venesection was done twice on consecutive days, and was the only measure, that brought down the blood pressure. (*Vide* chart.)

The patient was taken home on 18-3-37 at the request of his relatives.



Comment.—It is not always possible to distinguish between essential hypertension and secondarily contracted kidney. Age—secondarily contracted kidney is more common before the age of 40 and essential hypertension is more common after. A blood pressure over 250 mm. is in favour of essential hypertension. In secondarily contracted kidney the blood pressure which is between 200 and 220 is usually steady and is not affected by depletion and drugs that lower the blood pressure (Lewis). The presence of albumen and R. B. C. in the urine as well as retinal changes are in favour of secondarily contracted kidney.

COLLEGE HOSTELS.*

Ladies, Gentlemen and Young Friends,

I am here to do something which if I were wiser I should have refused to do But your secretaries have taken the measure of my vanity and were good enough to concede to me three conditions. You should not expect a long speech. You should not mind a speech without rhetoric. You would not look for ideas—original and strange. They have in fact gone as far as they could to make my task easy.

I was puzzled as to what I should say, where I could begin and how to end the speech. I therefore hailed with delight the report of the proceedings of a similar function elsewhere. But after going through it I was disappointed that I could not plagiarize the words and sentiments. For I realized that to say certain things in a certain way, you require a fame and a personality. That address was alright from the mouth of the Rt. Hon. Mr. Srinivasa Sastri. I have therefore to fall on my own resources.

On these occasions, the addresses generally begin with compliments, go on to advice and end with exhortations. They do not seem to be complete if there is not some digression on the advantage of a hostel life.

The ancient seats of learning were monasteries where the teachers and the taught lived on the premises away from the conflicts of ordinary life. The learning was not all, nor often, in the class room The daily routine of the teacher was itself a great education. The pupils observed how the teacher ordered his daily life, how he worked, what ideals inspired his conduct, what aspects of nature interested him and how he reacted to unusual and usual situations. The life in these monasteries was strictly disciplined. The discipline was not all meant for pupils. The teachers were under as great or greater discipline. The universities as we now know are the successors of these monasteries. The first universities retained some of the valuable ideals of these ancient monasteries, partial isolation from the outside world and the living together of the teachers and the pupils. The college hostels are the modern substitutes of this common life of the students.

But you will easily realize how far we have gone away from this original object. The object then was to isolate the seats of learning from the hurry and din of the business world. But the chief object now is to provide the student with a place where he could find lodging and board. This is essential for all senior students. It is particularly necessary for the medical student, especially for the students of the Madras Medical College. In

* Address to the students of the Madras Medical College on the occasion of their Hostel Day—1937.

many centres the hospitals where the students have to work are grouped about the college itself. But in Madras, the student has to go to different corners, the Maternity, the Ophthalmic, the Mental, the Isolation, the Tuberculosis hospitals in the North, South, North-West and South-West corners, and their hours of Lectures seem to be from morning to evening. Under these conditions if the student has to waste his time to and fro from their lodgings in all corners of Madras, one could easily understand the serious handicap under which the students have to learn their profession.

The want of a hostel for the men students of the Medical College is a time worn theme. Successive Surgeon-Generals and Principals have looked embarrassed at the request for a hostel. But I believe that the Government has after all agreed to move in the matter. I hope the selection of the site or the provision of funds would not further delay the construction of a hostel. Let us also hope that when the authorities decide upon the hostel, they would not merely cater to the limited ideal of finding lodgings for the students. They might as well keep the other objectives of a hostel in mind, *viz.*, that the hostel should ensure as far as possible the isolation from the noise and clamour of the business world. It is well to remember the ancient advice of the Syrian Saint : "Live apart from the highway and transplant thyself in some enclosed ground, for it is hard for a tree which stands by the wayside to keep her fruit till it be ripe." If a site could be found near the College it would be better. The students save the time of going to and fro, the Government saves the expense of providing ground and appliances for recreation and exercise and more important, the students will be nearby to attend any interesting and sudden demonstrations. One of the great advantages of students living together in a place which they feel is their own is the good fellowship which it encourages and the boisterous merriment in which they can often indulge without fear of being criticized as noisy neighbours by others. This hilarity and *bon hommie* is the best preventive in after years for the long face which some medical men affect in the presence of patients and their people. The doctor might feel that he is looking wise, but the patient is likely to feel that he is in the presence of a severely sober hangman.

The negligence of the College in not providing you with a hostel is not altogether an evil. For, if they had provided you with one, you could not have had this function here. You could not have demonstrated your great capacity for organization. You would not have yourself realized your undoubted ability to help yourself. Running of a hostel of this type where about 80 students are catered for by yourself needs leadership, loyalty and sacrifice. That you have run this hostel for three years proves the existence

of all these qualities among you, a quality which will be appreciated by you more and more in future years when you are called upon to organize and lead the profession in this part of the country. The seniors in the profession I am sure appreciate your initiative and admire the courage and skill with which you are able to run this hostel.

Advice is eagerly sought, but if ever it is accepted, it is most reluctantly so. Human nature is very varied and among its variations you would have observed two common types. There is a class of men, young and old, who are never so happy unless they acquaint their friends and relatives with every little difficulty that comes in their way. They all the time indulge in self-pity. They always ask for advice, but what they seek is sympathy. The other class is ever anxious to offer advice. They are so full of conceit. They have immense belief in their own wisdom and have an appropriate solution for every imaginable situation. When young men are foolish enough to act on such advice and get into trouble, the friend is silent and makes himself scarce. But when one has the courage to flout such advice and gets into trouble, the friend is already round the corner with his inevitable " I told you so." Neither of these is desirable in society. I hope you have none such among you.

What advice can I give you ? To be able to advise one must take into consideration all the circumstances in individual cases and who is more fully aware of these circumstances than yourselves ? You should therefore be your own advisers, and if in exceptional circumstances you are not able to make up your minds, your parents ought to be your best advisers. If your parents are at a loss to advise you, what better text can they or you follow than the words which Shakespere put into the mouth of Polonius ? You might turn round and ask, " how could we inexperienced young men, or our parents who may not be fully conversant with the needs of a medical student, advise on these occasions ? " Well then, you have every right to look to your teachers. But I would not ask them for advice. You come into intimate contact with them in the class room, laboratories and the wards. Observe them closely, see how early they come into the wards and how late they leave the hospital. See them in the wards, how carefully they examine the patients and with what pains they take notes. See how patiently they listen to the tales of woe and with what cheer they encourage and console the sick. Follow them into the library. See what labour they spend in preparing their notes for the class. Go into the museum and laboratories and observe how carefully they choose the specimens and arrange the apparatus for the next days' meeting And if you are lucky enough to meet them in the field or at social functions,

you should take note of their cheerful dealings with their colleagues and the dignified attitude towards the students. Such close observation is good for both of you. The teacher who knows that the eyes of his students are focussed on him makes an effort to live up to a standard and you have the benefit of advice in action.

I now come to the last portion of my task. To exhort you, you require a master-mind mellowed with age and widened by experience. We have simply none in our midst to inspire you with the lofty idealism of a life spent in teaching and working, enriching knowledge, ennobling the profession and exhaling sympathy and kindliness towards the suffering poor. The system of staffing the schools and colleges strictly prevents such personalities coming up. Your teachers are very much in the fight for the good things of life. They have ambition and anxieties. They are concerned now with promotion and now with practice. Such a state of affairs is not altogether a disadvantage. If we have no master-minds and pupils, we are at least all of us students, teachers and the taught—senior and junior students. It is certainly ridiculous for the senior students to exhort the juniors. But they can all think together and think aloud. If you are generous enough to concede to me for the moment a moiety of that capacity to think and if you are yourself in a mood to think a little, we might apply our minds to the problem of the future of the profession. This concerns the most junior among you and those who are on the threshold to graduate and to practise the profession.

If you look about you, you are depressed by the sight of struggling doctors and the thought inevitably comes up as to what is to happen to yourself. Unemployment is bemoaned and organization is urged. At the back of it all you will find an evil that is predominant. That evil is not-provincial, it is not national it is almost universal. But it is just now the most important cause of the difficulties of the profession in this part of India. I mean the lack of charity. The senior and the successful is often as green with envy as the most junior practitioner. It rarely occurs to the senior that he could lend a helping hand to the juniors in difficulty. If we could only shape our practice a little more on the old principle of "*live and let live*", there would be greater happiness in the profession. But this is a principle which is a little difficult to follow and you cannot achieve it to order. You have patiently to discipline yourself to it. And in your student days and in hostel life you have unrivalled opportunities of practising this. If you would consciously cultivate this trait while you live together in this hostel, I am sure you will carry that attitude into your life after college and thus be the pioneers of a new style and of a better standard of medical practice in this land.

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MAY 15, 1937.

THE HONORARY SCHEME

We believe that the Government is contemplating some changes in the working of the scheme of appointing honorary medical officers to the staff of the various public institutions. Within a few years of the inception of the scheme, the public were impressed with the successful possibilities of this method of increasing the medical personnel of the hospitals and dispensaries. By questions and amendments on the floor of the Legislative Council and personal interviews with responsible members, the Government was pressed to take action to widen the scope of the scheme. Two Committees were appointed to consider the enlargement and improvement of the scheme. As a result new orders were issued about three or four years ago. But there is a tendency in certain quarters to keep altering these rules.

A new departure or a new scheme has to be constantly watched for difficulties and defects in the working. But if every individual's inconvenience and temperamental disinclination is considered sufficiently important to propose change of rules, the scheme would soon degenerate into a medley of unintelligent zoo language.

Sometime ago we drew the attention of our readers to the G. O. which re-named the honorary medical officers with Licentiate qualification. We may agree that the original nomenclature was imperfect. But to have it altered into something which is decidedly clumsy is not an improvement. It was unnecessary and undesirable. And we have yet to learn what public interest has been served by this change.

It is widely remoured that the Government contemplates at present a more fundamental change in the policy of the honorary scheme At the recent conference of the District Medical Officers at the Office of the Surgeon-General the question of fixing a tenure for the honorary officers is said to have been discussed, and we further understand that these officers, or atleast most of them, agreed with the head of the department that it is desirable to fix a tenure. We are again in the dark as to the immediate provocation for this suggestion.

There are a few surmises as to the cause of this move. It is said that the practitioners in some of the district or taluk headquarters have complained of the lack of facility for gaining hospital experience. By allowing a few men to be on the hospital staff permanently, the others are denied the advantage of hospital experience. The District Officers have therefore recommended that by fixing a tenure for honorary officers all the practitioners in an area will get a chance of gaining hospital experience and thus improve the efficiency of medical men generally in the districts. If this be the considered view of the District Medical Officers or the Surgeon-General, the profession has achieved a success. This is a clear admission that association with hospitals increases the efficiency of the practitioner. Up to now when the profession desired honorary appointments on the hospitals, many irrelevant objections were generally raised. One of these was, that no practitioner who had any practice worth the name, would care to spend part of his time in free service in the hospitals. Therefore other and undignified motives were attributed for this demand for honorary appointments. We are therefore happy that honest realization has come to these Government Medical men about the true object of the honorary medical men.

But we wish we could be equally happy about the methods proposed to achieve this object of giving hospital training to the practitioners. Before deciding on altering the Rules and Regulations governing the Honorary Medical scheme, it is essential to work the existing scheme fully. It is only when it

is really essential that one should think of modifications. It is a long cry and a loud one that medical relief is still scanty in this country. Any one who has any pretence to be familiar with modern medical needs knows well that the medical staff of all the Government institutions is very meagre. The present strength of the verious medical service cadres is conditioned solely by financial resources. It has absolutely no relation to the scientific and clinical needs. We are sure that the present Surgeon-General is not over proud of the crowded out-patient departments. We are also certain that he would welcome a two or three-fold increase in the number of medical men to look after the ever increasing number of patients who seek advice at these centres. The last committee that considered the expansion of the honorary scheme recommended, and the Government has accepted that where the daily out-patient attendance was more than 100, there should be two medical men to attend to the patients. If this rule were seriously given effect to many of the practitioners will be enabled to be associated with the hospitals. We are aware of the usual objections that might be raised. Administrative convenience, architectural arrangements of the out-patient buildings, the idiosyncrasies of the various Medical Officers, all these and others might be advanced. But the ingenuity of the head of the department might be exercised a little and usefully to overcome these difficulties.

The staffing of the in-patient departments of the hospitals, including the Chief Presidency Hospital is not more adequate. Patients who should generally be looked after in the out patient departments are often admitted into the hospitals for investigation since the Medical Officer in the out-patient department has not the necessary leisure to examine the patients satisfactorily. And it would be worth while for some one to undertake statistical investigation of prolonged hospital-stay of patients on account of the delay in investigations. Translated into finance, it would not be negligible, and for the same budget allotment a large number of patients might be cared for. Even more important is the paucity of scientific achievement. Visitors to the various hospitals in Madras are struck by the abundance of clinical

material available. And they are even more surprised by the scantiness of contribution to medical knowledge from this country. One of the chief causes of this neglect is the want of sufficient number of doctors in these institutions. The available staff has its hands full with routine work. They have not the leisure for study and investigation. There is therefore need for increasing the staff of the various hospitals, in the Presidency town and in the mofussil. We can thus absorb almost all the practitioners. And for some years to come there will still be shortage of staff in spite of this. If thereafter a large number of practitioners cannot be thus provided for, one may think of other methods.

Thus far we have discussed the methods of staffing of the hospitals from the point of improving the efficiency of the practitioners. But this is not the only consideration. It is not even the main consideration. The first consideration in any scheme of medical relief is the interests of the sick public, both that which seeks admission into the state hospitals and the larger group which desires to be looked after by efficient medical men outside these hospitals. To deal with the former first, those who seek treatment in the hospitals expect efficient and adequate care. It would certainly not be desirable to have on the staff of these hospitals men without experience. To send out men by the time they have gained experience is certainly not the best method of gather ng an experienced and efficient medical staff to look after the sick public. It might be argued with some plausibility that the paid staff of the hospital might make up for this deficiency by their continued association with institutions. Even if this be true, the presence of experienced honorary medical men will certainly enhance the value of the hospital. But the contention that paid men are more experienced and therefore more efficient is not always true. The exigencies of service creates transfers fairly frequently. It often happens that the paid assistants are very junior men. In such circumstances, the presence of experienced honorary men is very helpful to a hospital.

The larger public which desires to be looked after in their own homes, or outside the state hospitals, really need the services of efficient men. They would certainly prefer to have in their midst practitioners who by reason of their continued association with public institutions, create greater confidence in the minds of the public. And the practitioners themselves in an area would welcome some of their senior men to be attached to the hospital, so that their services could be utilized in a consultative capacity. There is fear in the minds of some members of the profession, that this new idea of fixing a tenure of honorary medical men may be one of the methods by which the paid medical men hope to prevent such a class of senior practitioners coming into existence in the district and taluk headquarters. Many of the service medical men are keen about private practice. They find that with the increasing number of efficient practitioners coming into existence, the scope for general practice is diminishing. They desire to retain atleast the so-called consultant practice in their own hands. If local practitioners easily come upto hospital standards, the public would not requisition the services of Government Medical Officers to the present extent. We are loth to believe that this could be the motive for this move to fix a tenure. For, we have reasons to believe that the service medical men are rapidly coming to realize that chances of private practice on a large scale are diminishing except for a few who by virtue of their official position are still likely to command a type of practice, general or consultant.

Looked at from any aspect, there is nothing to recommend this proposal for fixing a tenure. On the other hand such a step would diminish the efficiency of hospitals and dispensaries and would further postpone the day when the country could feel assured of the existence of a large number of very, efficient medical practitioners in their midst. That such a step is contemplated shows that those who are responsible for the medical administration of this province have no real grasp of the medical needs of the present nor have they understood the purpose and significance of the honorary medical scheme.

GLEANINGS FROM MEDICAL LITERATURE.

1. THE USE AND ABUSE OF VITAMINS.

R. A. PETERS, M.C., M.D, F.R.S.

Practitioner, April 1937, 340 et seq.

Vitamins are essential constituents of a proper diet and are required in amounts which for each vitamin is a fairly accurately known irreducible minimum and the object of separately dosing with vitamin is to assure the daily supply of this enough minimum amount and provided this is reached together with enough reasonable reserve store, no extra dosing with vitamin should do good.

The vitamin content of even good food varies with cooking and storage—therefore it is wise to give a margin to cope with possible fluctuations in this diet. In the case of the water-soluble vitamins B and C there is no danger of overdose as excess is excreted in the urine. With the fat-soluble vitamin D there may be overdose although this is rare. The indiscriminate use of vitamins is both unscientific and uneconomical where their daily intake exceeds a reasonable daily margin, although excess is much less dangerous than too little.

Vitamin deficiency having been suspected, the ideal is to assure oneself that the diet of the patient is adequate in this respect. Thereafter the appropriate vitamin is exhibited. Failure to notice definite improvement within a fortnight or at the most one month should mean either that the condition is not due to vitamin deficiency or that the vitamin is not reaching the site of action. Injection may now be tried and if it has no effect there is no sense in continuing to dose with vitamin. All that is needed thereafter is to ensure that the patient eats a thoroughly good diet.

There is no doubt that apart from the proved effects of vitamin B in Beri-Beri, of C in Scurvy and D in Rickets, there are many clinical conditions that will be helped by this therapy. On the other hand the continued use of such preparations in the absence of clinical evidence of improvement is not merely wasteful but may be positively harmful. For instance it is not clear whether excessive Vitamin D in the elderly does not predispose to some form of calcification of the arteries.

S. R.

2. PROGNOSIS AND TREATMENT OF TUBERCULOSIS OF BONES OF THE FOOT.

LEO. T MIETNER AND H C. FANG.

Journal of Bone and Joint Surgery, April 1936.

The prognosis and treatment are governed by three factors, age of the patient, type and duration of the disease and social status of the patient.

In children conservative measures are generally sufficient.

In adults three operative procedures are used, curettage which is unsatisfactory, excision and amputation for advanced cases. By the excision method is meant excision of the affected bone or bones, the surrounding soft tissues together with a margin of healthy tissue in the same manner as would be done for a neoplasm, the wounds being left to heal or grafted with skin after two to five weeks This excision is indicated where the disease is so localized that even after the diseased area is entirely removed, a useful portion of the foot will remain. Thus astragalectomy or removal of fifth or the fourth and fifth metatarsals and toes (with or without cuboid) may be performed. The first metatarsal or even the first and second metatarsals and toes may be removed and the remaining portion of the toes may be quite satisfactory for ordinary use.

Treatment by careful surgical excision is an excellent method of management for advanced local lesions, especially those in adult patients.

P. G.

3. MANAGEMENT OF ARTHRITIS.

ROGER T. FAIRLEY.

Illinois Medical Journal, January 1937.

This author recommends the use of massive doses of vitamin D in the treatment of arthritis. Daily doses of 2,000,000 units or more on an average are given. Dizziness or nausea which develop in patients receiving these high doses can be reduced or controlled by brewer's yeast. Not a single one of the cases upon whom this treatment was tried has failed to respond in some degree to this therapy. The general nutritive state of the patient is also improved under this treatment as manifested by the gain in weight, appearance and feeling of well being.

P. G.

4. CHOREA TREATED WITH AVERTIN.

LESLIE COLE, M.D.

Lancet, 21-11-1936, p. 1213

Although untoward effects were anticipated by some, by the use at short intervals of Avertin, a drug having a profound effect on the body metabolism, it has on several occasions proved of great value in controlling the spasms of tetanus and so far from having ill-effects, repeated injections have on several occasions been a life-saving treatment.

A case is recorded of the successful treatment of Chorea in the same way. The patient was a girl of 11 years. The attack began on July 12th and on the 7th August when the patient was admitted movements were so violent that the patient could scarely drink even fluids, sleep or talk. During the first two days of treatment, subcutaneous Hyoscine, luminal and rectal sodium bromide only made the movements worse.

Avertin was started under chloroform anæsthesia in doses of 0·1 gm. per kg. of body weight, the patient going to sleep in quarter of an hour and movements were controlled for four hours, returning thereafter. Avertin was repeated, the dose being regulated by the violence of the movements. Patient was fed nasally.

Warmed oxygen given through the nose relieved the Cyanosis and fourth hourly 1/150 gn. injections of atropine were given at first and later less frequently. On the third day respiratory complications were noticed but since reduction of avertin dosage caused return of movements the chest symptoms were disregarded

A total of 115·5 c cm of avertin was given during 21 days; the maximum dose was 3 c.c. and the maximum number of doses per day 5. Definite improvement was seen on the 7th day and on the 9th day patient commenced taking small quantities fluid by the mouth. Movements practically ceased on the 29th September and the patient was discharged on the 10th of October with no movements and no signs of involvement of the heart.

M. K.

5. BLOOD PRESSURE DURING SPINAL ANÆSTHESIA.

E. FALKNER HILL.

The British Journal of Surgery, Vol XXVII, No. 95, pages 446 et seq.

Abdominal sections performed under spinal anæsthesia divide themselves into two very definite groups in so far as the fall of blood pressure that occurs is concerned.

1. Cases in which the blood pressure falls at once and steeply and before the peritoneum is opened. These comprise the acute abdominal conditions with great pain and so typical is the fall of blood pressure that it is almost diagnostic of the acuteness of the abdominal condition. The relief of pain and fall of blood pressure are simultaneous and both are caused by the action of the spinal anæsthetic on the posterior roots the sudden abolition of the pressor impluses to the vasomotor centre causing the fall of blood pressure The fall is too quick to be due to paralysis of the anterior roots (vasoconstrictors). The importance of this explanation lies in the fact that if this view is accepted no special treatment beyond a slight trendelenberg is necessary and this is reflected in the subjective sensation of the patient who although his blood pressure has fallen by almost half feels greatly improved.

On the other hand the steep-fall of blood pressure that occurs in the old, in the extremely nervous, in those overdosed with sedative drugs, in the fat and flabby, in those who are toxic as indicated by a high blood-urea and in the dehydrated must be met with by an immediate restoration of blood volume by intravenous saline.

2. The second group of cases comprise chronic conditions in which the fall of blood pressure coincides with abdominal exploration and is due to stimulation of the vagus.

The points stressed are that low blood pressure and 'shock' are not synonymous that fall of blood pressure after spinal anæsthesia being due to different causes requires different treatment, that many cases of low blood-pressure need no special treatment and low blood pressure when it does require treatment can frequently be remedied by measures less heroic than immediate intravenous saline.

M. K.

6. ADVANCES IN THE DIAGNOSIS AND TREATMENT OF DISEASES OF THE BLOOD FORMING ORGANS.

JOHN F. WILKINSON, M.SC., PH D., M.D., M.R.C.P., F.I.C.

Practitioner, October 1936, 435 et seq.

Pernicious anaemia is a permanent deficiency disease requiring adequate replacement therapy for the remainder of the patient's life. A combination of parenteral liver therapy in the early stages followed by oral stomach powder has proved a good method of treatment. The active principle of stomach preparations is *haemopoietin* which is produced by the pyloric glands of the stomach and Brunner's glands in the Duodenum. Hæmopoietin (intrinsic factor) reacts with the extrinsic factor in certain foods, to form either the liver anti-pernicious anæmia principle or a precursor of it, which is then absorbed in the alimentary tract and taken to and stored mainly in the liver as the anti-pernicious anæmia factor; interference with any stage of this formation or storage of this anti-pernicious anæmia factor leads to anæmia of the Addisonian type.

Achrostic Anaemia on the other hand is a severe megalocytic, hyperchromic anæmia, unaccompanied by either gastro-intestinal disturbances or C. N. S. changes or fever or evidence of hæmolysis. And although the bone-marrow shows a marked megalo blastic hyperplasia the stomach contains free acid and response to anti-pernicious anæmia treatment is totally absent. Intensive parenteral liver and oral stomach and liver and repeated blood-transfusion have maintained these patients for a time only, the disease ultimately proving fatal.

The Hypochromic Nutritional Anæmias are by far the commonest seen in medical practice and include the iron-deficiency anæmias of infancy and pregnancy, the anæmias secondary to hæmorrhage and chlorosis and idiopathic hypochromic anæmia. Achlorhydria, glossitis and koilonychia are frequent features and in some dysphagia. Treatment is simple and consists in replacing the deficiency of iron in the diet.

The value of copper salts, bile pigment and Chlorophyll in enabling the absorption of iron has been variously estimated.

Anaemias of the Haemolytic type still present difficulties in classification. For the actue hæmolytic anæmia of 'Lederer repeated blood-transfusions afford satisfactory treatment although the mortality is still high.

For acholuric jaundice splenectonny is best after preliminary blood-transfusion.

True Aplastic Anaemias following administration of arsenic, gamma and X-rays, Benzol and derivates, gold salts, dinitrophenol, hair dyes and shoe polishes continue to be reported. And although occasional cures by liver, stomach, spleen and thyroid therapy are reported, repeated blood transfusions remain the only treatment of any value.

The importance of the ætiological relationship between *Agranulocytosis* and the use of amidopyrin, dinitrophenols, arsphenamine, benzol, bismuth and gold salts has shown us the danger of their indiscriminate use. The disease may in its early stages be readily confused with acute leukæmia and aplastic anæmia. The essential features are (1) a history of sudden onset, (2) the occurrence of necrotic or ulcerative lesions in the mouth, (3) pyrexia and severe prostration, (4) absence of generalised glandular enlargement, (5) absence of hæmorrhages and (6) slight anæmia.

Treatment consists of (1) elimination of the cause, (2) 20-60 c.c. of pentonucleotide intramuscularly or intravenously daily until improvement in the blood is seen and gradually reducing to 20 and 10 c. c. for a few days each, (3) treatment of the buccal condition and (4) prevention of relapses. About 25 per cent of cases respond to treatment with or without blood transfusion which is a distinct advance over the previous mortality of 90 per cent.

The accurate diagnosis of acute Leukæmia demands a careful survey of all the available clinical and hæmatological data.

The most important signs are :

(1) a severe and rapidly progressing illness.

(2) severe anæmia.

(3) abnormal differential white cell count.

The chronic leukæmias as a rule are easily diagnosed. In addition to the lymphatic and the myeloid types a monocytic type is described although some believe it is only an atypical myeloid Leukæmia. X-rays remain the method of choice in the treatment of chronic Leukæmia, while in acute Leukæmia X-rays, liver, arsenic and hog's spleen are all equally inefficacious.

M. K.

7. BED-SORES AND THEIR TREATMENT.

R. J. McNEILL LOVE, M.S., F.R.C.S.

Practitioner, March 1937, 277 et seq.

Bed-sores are (1) trophic or acute or (2) postural or chronic. The former are associated with spinal cord disease or injury and have a poor prognosis.

Four factors encourage the formation of decubitus ulcers and they are in large measure preventible.

1. *Pressure* is to be avoided by using as large a surface as possible for weight-bearing and frequently redistributing it. For this frequent change of posture, the use of air cushions or the water-bed, the use of pillow as a "donkey" under the knees, cotton wool rests or rings of sorbo rubber over bony points and the use of a soft pillow beneath the small of the back are all to be tried.

2. *Trauma.* Injury to the skin may be due to maladjustment of such supports as rings and pads, to an overlain bread-crumb, to the use of harsh linen, to the use of linen impregnated with irritant chemicals and to small particles of grit in dusting powder. These should be avoided.

3. *Malnutrition of the skin,* which may be avoided by constant attention by the nursing staff and

4. *Maceration of the skin* which may be rendered sodden by sweat, urine, fæces or pus.

Treatment.

General. Fresh air, bright surroundings, adequate nourishment are essential. Iron is useful. Insulin in two five unit doses is of remarkable value even in non-diabetic cases.

Local Treatment. In the first stage, of the threatened bed sore moist dressings and ointments should be avoided and measures to harden an unduly soft skin adopted. For this purpose application of 5 per cent silver

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nitrate or equal parts of Liq. Plumbi Subacetatis and Tr. Catechu or the following lotion is useful.

Alum	30 grains.
Water } Alcohol }	250 c.c.—a.a.

If the skin is harsh and dry a protective covering of elastoplast or painting with several layers of Collodion Flexile is best. It is important not to stretch the elastoplast before applying it.

In the second stage of the inevitable bed-sore and ulceration is imminent the best form of local treatment is a freshly prepared 5 per cent Tannic acid spray used exactly as for the treatment of burns.

In the final or third stage of actual ulceration.—Ointments and other greasy preparations are not suitable. In the early stages a good method is to cover the area with elastoplast which is applied without stretching. This is left in position until loosened by the discharge, when the ulcer is cleaned with sterile dry gauze and the plaster reapplied. This is repeated as often as necessary. This treatment which resembles the Winnet Orr treatment for acute Osteomyelites is simple, requires little skilled nursing and leaves the granulations unimpaired by frequent dressings. Extending bed-sores when protection by plaster has failed are the only variety requiring moist applications for which any such antiseptic as dettol, eusol or flavine could be used. It is sometimes of advantage to change from one antiseptic to another.

When healing is reached, a 10 per cent. Ichthyol and Glycerine dressing expedites it. At a later stage stimulating dressings with a view to encourage the growth of epithelium such as Lotio Rubra or equal parts of Zinc Oxide and Resin ointment are useful. Skin grafting should be decided on general principles.

M. K.

MEDICAL COUNCILS

NOTICE

THE PUNJAB MEDICAL COUNCIL.

Lahore, dated the 17th April, 1937.

LAHORE,
16th April, 1937,

An unqualified medical practitioner fined.

Judgment has been delivered by the Additional District Magistrate of Jullundur in a case under Section 6 of the Indian Medical Degrees Act, 1916, and under Section 23 of the Punjab Medical Registration Act II of 1916, in which one Hazara Ram Dard of Nawanshahr, District Jullundur, an unqualified medical practitioner, who exhibited the qualification of "M.B, Ch B." after his name and described himself as a "registered" medical practitioner, was found guilty and was fined Rs. 50 or in default two months' imprisonment. The complaint was lodged by the Punjab Medical Council with the sanction of the Local Government.

MEDICAL COUNCIL OF INDIA.

No. F. 139/2/37.

Dated Simla, the 28th April 1937.

Press Note.

An intimation has been received from the Registrar of the General Medical Council of Great Britain to the effect that the medical qualifications of the Punjab University have been recognised with effect from February 25, 1930. These qualifications were recognised only up to February 24, 1930. The significance of the retrospective effect to this notice is that now there will be no gap in the recognition of these qualifications by the General Medical Council.

The Executive Committee of the General Medical Council have deferred their decision on the recognition of the medical qualifications of the Universities of Calcutta and Rangoon till their next meeting on 24th May, 1937.

For difficult Infant Feeding Cases

The difficulties and trouble of predigesting and peptonising milk for the use of invalids and others suffering from gastric weakness are now overcome by this highly scientific preparation. Peptalac is a dry stable powder. The simple addition of hot water yields a predigested and peptonised Full Cream Milk. Peptalac is not only invaluable to invalids, but, containing as it does a proportion of predigested wheat flour, it will serve as an ideal food to wean infants taking more solid foods at 8—9 months.

PEPTALAC

Brestol is an emulsion of 50% Fats, 40% Dextrose and contains biologically tested cod liver oil and orange juice. It is indicated in all cases where an increase of weight is desired, and for all forms of milk modification.

BRESTOL

This is a lactic acid milk in powder form, made in three strengths, namely Lacidac Separated (1% Fat), Lacidac Half Cream (16% Fat), and Lacidac Full Cream (27% Fat). It is proving of great value in the feeding of infants recovering from gastro-enteritis, broncho-pneumonia, and other diseases, and eliminates the difficulties and disadvantages of administering liquid milk treated with lactic acid, as proposed by Marriott.

LACIDAC

This was prepared originally for the special requirements of a well-known pediatrician for the feeding of premature and frail infants. It contains a large percentage of easily assimilated sugar, a condition which is very necessary in the feeding of these infants. The successful application of Frailac has prompted us to widen its utility amongst the medical profession. Frailac is not intended as a permanent food but on normality being reached our Half Cream Cow & Gate is specially recommended.

FRAILAC

This is a Full Cream Milk to which has been added Iron Ammonium Citrate B.P. and subsequently powdered by the Cow & Gate Improved Roller Process. It was the food used exclusively in the now famous investigations by Dr. H. M. M. Mackay on Nutritional Anæmia in Infancy (Medical Research Council Report, Special Series No. 157). Hemolac is indicated in the Nutritional Anæmia of infancy, and for premature infants.

HĒMOLAC

These Foods are indicated for all cases of fat intolerance such as is indicated in cœliac disease and gastro-intestinal disorders. They are both standardised Cow & Gate preparations. Attention is also drawn to the fact that the Special Half Cream Food (containing no extra lactose) is still available.

SEPARATED & HALF CREAM

This has been prepared at the request of a leading London Hospital for the treatment of allergy in infancy. It is characterised by the fact that its protein is denatured, that it is practically free from lactalbumen, and that its pH value has been suitably modified.

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Prolac is a protein milk in powder form based on the Eiweissmilch of Finkelstein. It is indicated in the dyspepsias and diarrhoeas of infancy which are due to abnormal sugar fermentation by bacteria in the large bowel. The milk is high in protein and low in sugar, and also contains a slightly lower fat content than the standard food.

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ASSOCIATION NOTES.

THE SOUTH INDIAN MEDICAL UNION.

A meeting of the Council of the Union was held on the 8th April 1937, at 5-45 p.m. at 32, Broadway, Madras.

The following Members were present:

Dr. M. Subramania Iyer.
,, E. V. Srinivasan.
,, T. Satakopan.
,, K. C. Paul.
,, G. Zachariah.
,, M. Krishnamurthi.
,, P. Govinda Rao.

Dr. M. Subramania Iyer presided.

The minutes of the previous meeting were read and confirmed.

The application for Membership from the following gentlemen were considered. The Council decided to enrol them as members.

Dr. S. Subbanarayanan, Dr. K. Sambandam, Dr. N. Natesan, Dr. T. K. Sundaram, Dr. V. Rangachari, Dr. S. Deivasikamani, Dr. S. A. Ghani, Dr. D. Balaraman, Dr. P. Martanda Pillay, Dr. N. Gangadharan, Dr. E. S. Gopalan, Dr. N. Kolappa Pillai, Dr. R. Krishnaswami, Dr. O. G. C. Vaz, Dr. K. R. Doraiswami, Dr. K. C. Koshy, Dr. A. V. S. Sarma, Dr. P. R. Srinivasachari, Dr. C. L Charles, Dr. D. Madhava Rao, Dr. V. S. Mahadevan, Dr. P. R. Nagarajan and Dr. T. N. Krishnaswami.

A Clinical Meeting of the Union was held on the 8th April 1937, at 6 p.m. at 32, Broadway, Madras.

Dr. K. C. Paul, M D., gave a lecture on "Peripheral Nerve Affections complicating Diabetes Mellitus".

Dr. M. Subramania Iyer presided.

The following Members were present:

Dr. M. Subramania Iyer, Dr. E. V. Srinivasan, Dr. T. Satakopan, Dr. P. Govinda Rao, Dr. M. Krishnamurthi, Dr. G. Zachariah, Dr. S. Rajagopal, Dr. P. S. Varadachari, Dr. P. Natesan, Dr. V. Govindarajulu, Dr. C. L. Charles, Dr Richard Appel, Dr. J. A. S. Masilamani, Dr. V. C. Sudarsanam, Dr. T. Venkateswara Rao, Dr. S. Deivasikamani, Dr. V. Rangachari, Dr. C. R. Krishnaswami, Dr K. C. Paul, Dr. D. Balaraman and Dr. N. Natesan.

After the lecture there was a discussion, in which the following members took part:

Dr. E. V. Srinivasan, Dr. V. Rangachari, Dr. C. R. Krishnaswami, Dr. Richard Appel, Dr. T. Satakopan, Dr. P. Govinda Rao and Dr. Deivasikamani.

RAMNAD MEDICAL ASSOCIATION.

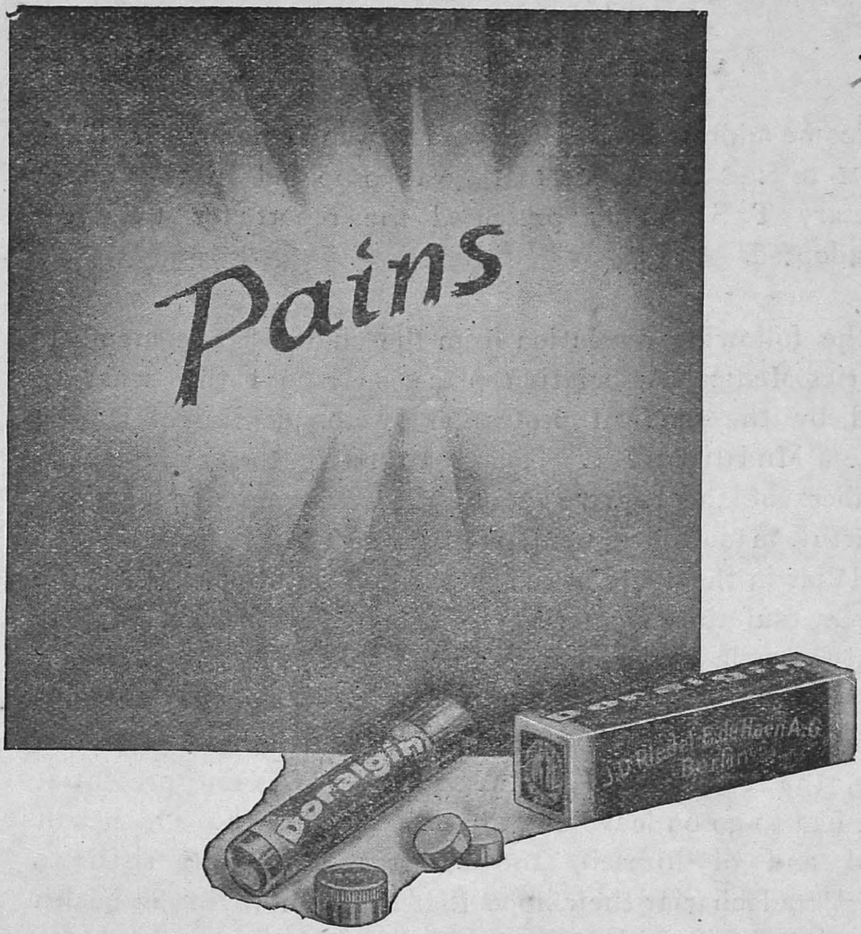
The seventh Annual gathering of the Ramnad District Medical Association (formerly Chettinad Medical Association), affiliated to the Indian Medical Association, took place on Saturday the 10th April 1937 at the S. M. S. High School buildings, Karaikudi.

The proceedings began at 10-30 A.M. with the general body meeting presided over by Dr. F. Ysander, Vice-President of the Association in the absence of the President Dr. B. V. Varadachariar, District Medical Officer, Ramnad. The following Office-bearers were elected for the new year:—

President	...	Captain B. Dayananda, Rao, A.I.R.O.
Vice-President	...	Dr. F. Ysander.
Secretary	...	K. S. Srinivas.
Joint Secretary	...	F. R. Ratnaswami.
Treasurer	...	S. Subramanian.

Members of the Executive Committee:—

		Miss E. Ivatts.
		T. S. Shetty.
		S. Rajaram Bharathi.
		M Krishnaswami.
Auditors	...	M. S. Venkataseshan.
		R. Bheem Singh.



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After the welcome address by Dr. F. Ysander, Rao Bahadur Dr. T. S. Tirumurthi, B A., M. B. & C. M., D. T. M. H., was proposed to the chair. The outgoing secretary T. S. Shetty presented the report for the year 1936-37 and it was adopted.

In moving the following resolution from the chair—"The members of the Ramnad District Medical Association place on record the sense of great loss sustained by the medical profession by the demise of Dewan Bahadur Dr. C. Natesa Mudaliar, M. L. C., and authorise the secretary to convey to the members of the bereaved family their sympathy in their grief." Dr Tirumurthi made an appreciative reference to the work of the late Dr. Natesa Mudaliar in the cause of the profession and hoped that the public would raise a suitable memorial to him. This resolution was passed unanimously the whole gathering standing.

In his presidential address Dr. Tirumurthi felt sorry that Dr. B. V. Varadachariar, the President of the Association, was not present at the conference as he had to go on leave due to indifferent health. On behalf of those assembled and of himself, the secretary was authorised to communicate to Dr. Varadachariar their hope that he is improving in health and prayed for his perfect recovery, happiness and long years of usefulness to the profession.

Dr. V. Rama Kamath spoke of the good work done by the Ramnad District Medical Association which was replied to by S. Subramanian and T. S. Shetty.

After reading messages from sister associations and well-wishers by T. S. Shetty, the gathering adjourned for lunch.

The afternoon session started with a paper on "Traumatic affection of joints" by Dr. R. Kalamegham of Trichinopoly. Dr. S. T. Achar, M.D., of Tanjore could not attend the meeting and in his place Dr. S. Padmanabha Sarma, M.B. & C.M., District Medical Officer, Madura, spoke on "Empyema." The Chairman delivered an interesting and impressive lecture on "Modern conception of the Pathology of Bright's Disease." After discussion on these subjects the President in his concluding remarks congratulated the Association on its usefulness to the profession and was greatly pleased to find that members from distant parts attended the meeting.